

**LIST OF EXHIBITS**

- A. 3-Responses from Terri Pechner-James with jurat.
- B. 3-Responses from Sonia Fernandez with jurat.
- C.1 Medical Authorizations of Terri Pechner-James & Certificate of Service
- C.2 Medical Authorizations of Sonia Fernandez & Certificate of Service
- D. Plaintiffs February 17, 2006 Letter to Reardon, Joyce & Akerson, P.C.
- E. Response from MGH HealthCare Center dated Feb, 13, 2006.
- F. Electronic Certificate of Service Missing From The Akerson document.
- G. February 6, 2006 Letter to Reardon, Joyce & Akerson, P.C. about Dr. Barry.

**EXHIBIT A**

**EXHIBIT B**

**CERTIFICATE OF SERVICE**

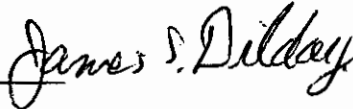
I, hereby certify that I served the following documents electronically to the City of Revere, Thomas Ambrosino, Mayor, Revere Police Department, Terrence Reardon, Chief, by emailing said documents and sending said documents to the parties listed below by regular mail, postage prepaid:

Plaintiffs Request For Reconsideration of Order On Motion For  
Sanctions:Docket #115 and Exhibits A through G.

Walter H. Porr, Esq.  
Paul Capizzi, Esq.  
Office of the City Solicitor  
281 Broadway  
Revere, MA 02151

John K. Vigliotti, Esq.  
Michael J. Akerson, Esq.  
Reardon, Joyce & Akerson, P.C.  
397 Grove Street  
Worcester, MA 01650

/s/ James S. Dilday, Esq.  
James S. Dilday, Esq.  
27 School Street, Suite 400  
Boston, MA 02108  
(617) 227-3470



Date: February 22, 2006

**EXHIBIT C-1**

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES

hereby authorize: DEBORAH WALD, M.D.

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),

~~Boston MA 02108, all protected health information, medical, hospital, psychiatric, and~~

psychological records without limitation regarding my medical, mental health condition, drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or tests for or infection with human immunodeficiency virus (HIV) as revealed by your observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing conditions, complications, aggravations, doctor's orders, laboratory reports, intake evaluation, and discharge summaries, operative and physical therapy reports, counseling records and any and all writings comprising the full and complete documentation of my medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

<u><i>Lawrence</i></u>		<u>                    </u>	
Signature of patient or patient's representative		Date	
<u>1 Patrick Lane</u>	<u>Georgetown</u>	<u>MA</u>	<u>01833</u>
Patient's Address	City	State	Zip
<u>1978-3525365</u>	<u>0429-73</u>	<u>                    </u>	
Patient's telephone #	Date of Birth	Relationship to patient or authority to act for patient	

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES

hereby authorize: DR. ELIZABETH MILLER

\_\_\_\_\_

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108, all protected health information, medical, hospital, psychiatric, and~~  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
tests for or infection with human immunodeficiency virus (HIV) as revealed by your  
observation or treatment, past, present and future.

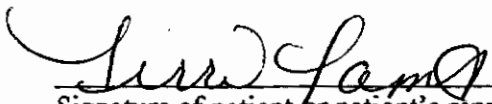
This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing  
conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
evaluation, and discharge summaries, operative and physical therapy reports, counseling  
records and any and all writings comprising the full and complete documentation of my  
medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my  
physical or mental health condition past, present or future and therefore specifically



includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

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<u></u>		<u>1/26/2006</u>	
Signature of patient or patient's representative		Date	
<u>1 Patriot Lane</u>		<u>Georgetown</u>	<u>MA 01883</u>
Patient's Address		City	State Zip
<u>978-852-5965</u>	<u>4/29/1973</u>		
Patient's telephone #	Date of Birth	Relationship to patient or authority to act for patient	

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES

hereby authorize: DR. SUSAN RUDMAN

\_\_\_\_\_

\_\_\_\_\_


to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108, all protected health information, medical, hospital, psychiatric, and~~  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
tests for or infection with human immunodeficiency virus (HIV) as revealed by your  
observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing  
conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
evaluation, and discharge summaries, operative and physical therapy reports, counseling  
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<u></u>		<u>1/26/2006</u>	
Signature of patient or patient's representative		Date	
<u>1 Patient Care</u>	<u>Georgetown</u>	<u>MA</u>	<u>01833</u>
Patient's Address	City	State	Zip
<u>1-978-352-5905</u>	<u>4-29-73</u>		
Patient's telephone #	Date of Birth	Relationship to patient or authority to act for patient	

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, **TERRI PECHNER JAMES**,

hereby authorize: **DR. BARRY**

\_\_\_\_\_

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
tests for or infection with human immunodeficiency virus (HIV) as revealed by your  
observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing  
conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
evaluation, and discharge summaries, operative and physical therapy reports, counseling  
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medical or mental health treatment at your facility for examination and photocopying.

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<u><i>Turn Lamb</i></u>		<u>1/26/2006</u>	
Signature of patient or patient's representative		Date	
<u>1 Palmoe Lane</u>	<u>Georgetown</u>	<u>MA</u>	<u>01833</u>
Patient's Address	City	State	Zip
<u>978-352-5765</u>	<u>4/29/1973</u>		
Patient's telephone #	Date of Birth	Relationship to patient or authority to act for patient	

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, TERRI PECHNER JAMES

hereby authorize: ERIC J. KEROACK, MD

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
tests for or infection with human immunodeficiency virus (HIV) as revealed by your  
observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing  
conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
evaluation, and discharge summaries, operative and physical therapy reports, counseling  
records and any and all writings comprising the full and complete documentation of my  
medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my  
physical or mental health condition past, present or future and therefore specifically



includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I have carefully read and understand the above statements, and do herein expressly and voluntarily authorize disclosure of the information hereby requested, to my attorneys Grayer & Dilday. I understand that this authorization is subject to revocation at any time by requesting such of the above-referenced hospital or party in writing unless action based on it has already begun. I understand that this authorization is will expire 90 days from date of said authorization. I am willing that a photocopy of this authorization be accepted with the same authority as the original.

<u><i>Ann Jan</i></u>		<u>1/26/2006</u>	
Signature of patient or patient's representative		Date	
<u>1 Patriot Lane</u>	<u>Georgetown</u>	<u>Ma</u>	<u>01833</u>
Patient's Address	City	State	Zip
<u>1978-322-5962</u>	<u>4-27-1973</u>		
Patient's telephone #	Date of Birth	Relationship to patient or authority to act for patient	

**CERTIFICATE OF SERVICE**

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Terri Pechner-James by mailing to them at the addresses listed herein:

1. Eric Keroack, M.D.  
103 Broadway St.  
Revere, MA 02151
2. Susan Rudman  
70 Washington Street, suite 211  
Salem, MA 01970
3. Dr. Barry  
268 Main Street  
Stoneham, MA
4. Dr. Elizabeth Miller  
Dr. Deborah Wald  
Massachusetts General Hospital  
300 Ocean Avenue  
Revere, MA 02151

  
James S. Dilday, Esq.

Date: January 26, 2006



**EXHIBIT C-2**

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ

hereby authorize: MCH REVERE HEALTH CENTER

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
tests for or infection with human immunodeficiency virus (HIV) as revealed by your  
observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing  
conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
evaluation, and discharge summaries, operative and physical therapy reports, counseling  
records and any and all writings comprising the full and complete documentation of my  
medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my  
physical or mental health condition past, present or future and therefore specifically

includes any doctor, nurse, psychiatrist, psychologist, counselor, social worker or therapist who has examined, interviewed, or treated me, and any facility or hospital where I have been examined, interviewed or treated.

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Sonia Fernandez

Signature of patient or patient's representative

1/24/06

Date

Patient's Address

City

State

Zip

Patient's telephone #

Date of Birth

Relationship to patient or authority  
to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ

hereby authorize: NORTH SUFFOLK COUNSELING SERVICES

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
tests for or infection with human immunodeficiency virus (HIV) as revealed by your  
observation or treatment, past, present and future.

This includes history, findings, x-rays, notes, diagnosis, prognosis, pre-existing  
conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
evaluation, and discharge summaries, operative and physical therapy reports, counseling  
records and any and all writings comprising the full and complete documentation of my  
medical or mental health treatment at your facility for examination and photocopying.

This authorization extends to any party who has medical information concerning my  
physical or mental health condition past, present or future and therefore specifically

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Sonia Fernandez

Signature of patient or patient's representative

1/24/06

Date

Patient's Address

City

State

Zip

Patient's telephone #

Date of Birth

Relationship to patient or authority to act for patient

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ

hereby authorize: BETH ISRAEL DEACONESS EAST BOSTON NEIGHBORHOOD HEALTH  
CENTER

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
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observation or treatment, past, present and future.

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conditions, complications, aggravations, doctor's orders, laboratory reports, intake  
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Sonia Fernandez

Signature of patient or patient's representative

1/24/06

Date

Patient's Address

City

State

Zip

Patient's telephone #

Date of Birth

Relationship to patient or authority to act for patient



**CERTIFICATE OF SERVICE**

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed  
Authorization To Release Protected Health Information, Medical, Hospital, Mental  
Health And Other Records for Sonia Fernandez by mailing to them at the addresses listed  
herein:

1. MGH Chelsea Health Center  
151 Everett Av. Chelsea,  
MA 02150

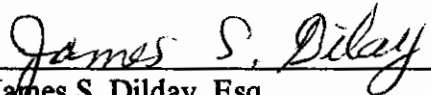
Beth Israel Deaconess Health Care  
East Boston Neighborhood Health Center  
1000 Broadway,  
Chelsea, 02150

Massachusetts General Hospital Revere health Center  
300 Broadway  
Revere, MA 02151

North Suffolk Counseling Services  
301 Broadway,  
Chelsea, MA 02150

Occupational Health Rehabilitation Center  
1 Harborside Drive,  
E. Boston, MA 02128

Meditrol, Inc.  
145 Springfield Street  
Chicopee, MA 01013

  
James S. Dilday, Esq.

Date: January 26, 2006



**CERTIFICATE OF SERVICE**

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed Authorization To Release Protected Health Information, Medical, Hospital, Mental Health And Other Records for Sonia Fernandez by mailing to them at the addresses listed herein:

1. MGH Chelsea Health Center  
151 Everett Av. Chelsea,  
MA 02150

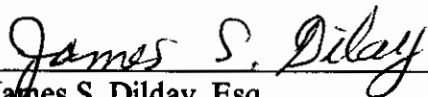
Beth Israel Deaconess Health Care  
East Boston Neighborhood Health Center  
1000 Broadway,  
Chelsea, 02150

Massachusetts General Hospital Revere health Center  
300 Broadway  
Revere, MA 02151

North Suffolk Counseling Services  
301 Broadway,  
Chelsea, MA 02150

Occupational Health Rehabilitation Center  
1 Harborside Drive,  
E. Boston, MA 02128

Meditrol, Inc.  
145 Springfield Street  
Chicopee, MA 01013

  
James S. Dilday, Esq.

Date: January 26, 2006

**AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS**

I, **SONIA FERNANDEZ**

hereby authorize: **MGH\_CHELSEA HEALTH CENTER**

\_\_\_\_\_

\_\_\_\_\_

to disclose and release to my attorneys, **Grayer & Dilday, 27 School Street (Suite 400),**  
~~**Boston MA 02108**~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
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Sonia Fernandez  
Signature of patient or patient's representative

1/24/06  
Date

Patient's Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient's telephone # \_\_\_\_\_

Date of Birth \_\_\_\_\_

Relationship to patient or authority  
to act for patient \_\_\_\_\_

AUTHORIZATION TO RELEASE PROTECTED HEALTH  
INFORMATION, MEDICAL, HOSPITAL, MENTAL  
HEALTH AND OTHER RECORDS

I, SONIA FERNANDEZ

hereby authorize: OCCUPATIONAL HEALTH & REHABILITATION CENTER

to disclose and release to my attorneys, Grayer & Dilday, 27 School Street (Suite 400),  
~~Boston MA 02108~~, all protected health information, medical, hospital, psychiatric, and  
psychological records without limitation regarding my medical, mental health condition,  
drug abuse, alcohol abuse, sexually transmitted diseases, rape/sexual abuse, child/elder  
abuse, abuse of an adult with disability, acquired immunodeficiency syndrome (AIDS) or  
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Sonia Fernandez  
Signature of patient or patient's representative

1/24/06  
Date

Patient's Address

City

State

Zip

Patient's telephone #

Date of Birth

Relationship to patient or authority  
to act for patient

**EXHIBIT D**

## **Grayer & Dilday, LLP**

COUNSELLORS-AT-LAW  
27 SCHOOL STREET - SUITE 400  
BOSTON, MASSACHUSETTS 02108  
TEL. (617) 227-3470 • FAX (617) 227-9231

February 17, 2006

John K. Vigilotti, Esq.  
Reardon, Joyce & Akerson, P.C.  
397 Grove Street  
Worcester, MA 01605

Re; Pechner-James and Fernandez-Medical Releases

Dear Attorney Vigliotti,

On January 26, 2006, we sent you the following documents on Terri Pechner-James:

1. Release of Medical Records sent to the following parties:

Eric J. Keroack, M.D.  
103 Broadway  
Revere, MA 02151

Dr. Susan Rudman  
70 Washington Street, Suite 211  
Salem, MA 01970

Dr. Barry  
268 Main Street  
Stoneham, MA

Dr. Elizabeth Miller  
Dr. Deborah Wald  
Massachusetts General Hospital  
300 Ocean Avenue  
Revere, MA 02151

We also provided you with the attached Certificate of Service. We have provided you with the records from Dr. Rudman. Our letter to Dr. Barry has been returned and after a diligent search we have been unable to locate him. On February 6, 2006, we sent you a letter requesting your help with locating Dr. Barry because he provided services to the police officers of the City of Revere. We have not received a response from you.

We have not, to date, received additional records from the other parties named in the certificate of service.

On January 26, 2006, we sent you the following documents on Sonia Feranadez.

Release of Medical Records sent to the following:

MGH Chelsea Health Center  
151 Everett Avenue  
Chelsea, MA 02150

Beth Israel Deaconess Health Care  
East Boston Neighborhood Health Care  
1000 Broadway  
Chelsea, MA 02150

Massachusetts General Hospital  
Revere Health Center  
300 Broadway  
Revere, MA 02151

North Suffolk Counseling Service  
301 Broadway  
Chelsea, MA 02150

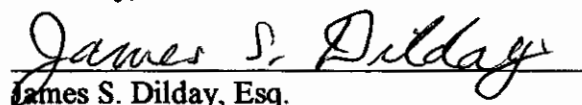
Occupational Health Rehabilitation Center  
1 Harborside Drive  
East Boston, MA 02128

Meditrol, Inc.  
145 Springfield Street  
Chicopee, MA 01013

We have not yet received additional records from these providers.

We would like to make the following suggestion. If you prepare releases on your letter-head, forward them to us, we would have our clients sign them and we will return them to you so that you can send them directly to the providers named herein. Please give us a call if you have any questions.

Sincerely,

  
James S. Dilday, Esq.



**CERTIFICATE OF SERVICE**

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed  
Authorization To Release Protected Health Information, Medical, Hospital, Mental  
Health And Other Records for Sonia Fernandez by mailing to them at the addresses listed  
herein:

1. MGH Chelsea Health Center  
151 Everett Av. Chelsea,  
MA 02150

Beth Israel Deaconess Health Care  
East Boston Neighborhood Health Center  
1000 Broadway,  
Chelsea, 02150

Massachusetts General Hospital Revere health Center  
300 Broadway  
Revere, MA 02151

North Suffolk Counseling Services  
301 Broadway,  
Chelsea, MA 02150

Occupational Health Rehabilitation Center  
1 Harborside Drive,  
E. Boston, MA 02128

Meditrol, Inc.  
145 Springfield Street  
Chicopee, MA 01013

  
James S. Dilday, Esq.

Date: January 26, 2006

**CERTIFICATE OF SERVICE**

I, James Dilday, hereby certify that I served upon the parties listed below the enclosed  
Authorization To Release Protected Health Information, Medical, Hospital, Mental  
Health And Other Records for Terri Pechner-James by mailing to them at the addresses  
listed herein:

1. Eric Keroack, M.D.  
103 Broadway St.  
Revere, MA 02151
2. Susan Rudman  
70 Washington Street, suite 211  
Salem, MA 01970
3. Dr. Barry  
268 Main Street  
Stoneham, MA
4. Dr. Elizabeth Miller  
Dr. Deborah Wald  
Massachusetts General Hospital  
300 Ocean Avenue  
Revere, MA 02151

  
James S. Dilday, Esq.

Date: January 26, 2006

## Grayer & Dilday, LLP

COUNSELLORS-AT-LAW  
27 SCHOOL STREET - SUITE 400  
BOSTON, MASSACHUSETTS 02108  
TEL. (617) 227-3470 • FAX (617) 227-9231

February 6, 2006

Michael Akerson, Esq.  
John Vigliotti, Esq.  
Reardon, Joyce & Akerson, P.C.  
397 Grove Street  
Worcester, MA 01605

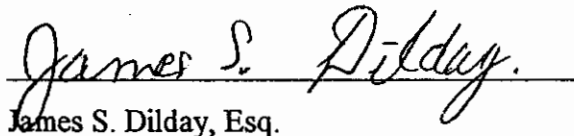
Re: Sonia Fernandez' records held by Dr. Barry

Dear Attys Akerson and Vigliotti,

The request for documents that we sent to Dr. Barry has been returned to this office because the postal service was unable to deliver it. The purpose of this letter is to ask you to provide us with the correct address of Dr. Barry so that we can send the request to that address. Dr. Barry was a medical contractor for the City of Revere. The Plaintiffs have had no contact with him since the end of their employment with the City of Revere.

We look forward to hearing from you.

Sincerely,

  
James S. Dilday, Esq.

**EXHIBIT E**

MGH CHELSEA HEALTHCARE CENTER  
HEALTH INFORMATION  
151 EVERETT AVE.  
CHELSEA, MA 02150

Attn: JAMES S. DILDAY, ESQ  
GRAYER & DILDAY, LLP  
COUNSELLORS AT LAW  
27 SCHOOL ST. SUITE 400  
BOSTON, MA 02108

February 13, 2006

TEL: 617-227-3470

RE: 1815062 FERNANDEZ, SONIA

Your request concerning the above mentioned patient has been received and is being returned for the reason (s) indicated below:

( ) We have no record of this patient having been treated at the hospital.

( ) Patient was not seen on the date (s) indicated on your request.

( ) We cannot release medical information without first receiving a signed original authorization from the patient or, if the patient is deceased or a minor, from the authorized representative or from the next of kin.

( ) Additional information is needed to identify this patient, i.e., date of birth, spelling of name or possible other name of treating M.D. or clinic, approximate date of visit/treatment.

( ) Please return your signed request along with the address of the physician, attorney, or other agency to whom you wish your records sent.

( ) copying fee of \$125.60 is required.  
COPIES WILL BE SENT UPON RECEIPT OF PAYMENT.  
( ) other:

Thank you for your cooperation.

Sincerely

Sharon Cecca,  
Correspondence Section,

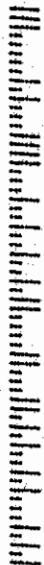
151 Everett Avenue, Chelsea, MA 02150

MGH Chelsea  
HealthCare Center



Attn: JAMES S. DILDAY, ESQ  
GRAYNER & DILDAY, LLP  
COUNSELLORS AT LAW  
27 SCHOOL ST. SUITE 400  
ROSTON, MA 02108

02108+4633-39 C013



CONFIDENTIAL



UNITED STATES POSTAGE  
PITNEY BOWES  
02 1A \$00.39  
0004394377 FEB 14 2006  
MAILED FROM ZIP CODE 02114

**EXHIBIT F**

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**CM/ECF Administrative Procedures**

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2. Unless exempt or otherwise ordered by the court, all pleadings and other papers must be served on other parties by electronic means. Any pleading or other paper served by electronic means must bear a certificate of service in accordance with Local Rule 5.2(b) stating that the document has been filed electronically and that it will be served electronically to registered ECF participants and by sending paper copies to non-registered participants as indicated on the NEF.

Example:

Certificate of Service

I hereby certify that this document(s) filed through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non registered participants on   (date)  .

3. Transmission of the NEF through the court's transmission facilities will constitute service of the filed document upon a registered ECF user and shall be deemed to satisfy the requirements of Fed.R.Civ.P.5(b)(2)(D), Fed.R.Civ.P.77(d) and Fed.R.Crim.P.49(b). The attorney filing the document electronically is responsible for serving a paper copy of the document by mail in accordance with Fed.R.Civ.P.5(b) to those case participants who have not been identified on the NEF as electronic recipients.
4. Service by electronic means shall be treated the same as service by mail for the purpose of adding three (3) days to the prescribed period to respond. In accordance with Local Rule 7.1, a party opposing a motion, shall file an opposition to the motion within fourteen (14) days after service of the motion, unless another period is fixed by rule or statute, or by order of the court. The fourteen day period is intended to include the period specified by the civil rules for mailing time and provide for a uniform period regardless of the use of the mails.

**F. Subsequent Documents with Fee Requirement**

Subsequent documents filed in a case which require a fee, such as a notice of appeal, motion for leave to appear pro hac vice, etc. must be electronically filed. However, until the court implements a credit card payment option through ECF, the required fee must be paid within 24 hours after the document is submitted electronically. A copy of the Notice of Electronic Filing should be submitted with the fee to the clerk's office so that it can be properly reconciled with the case.



**EXHIBT G**

## Grayer & Dilday, LLP

COUNSELLORS-AT-LAW  
27 SCHOOL STREET - SUITE 400  
BOSTON, MASSACHUSETTS 02108  
TEL. (617) 227-3470 • FAX (617) 227-9231

February 6, 2006

Michael Akerson, Esq.  
John Vigliotti, Esq.  
Reardon, Joyce & Akerson, P.C.  
397 Grove Street  
Worcester, MA 01605

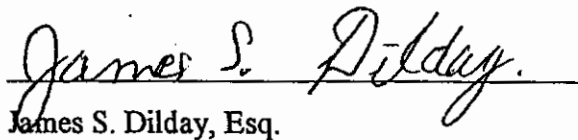
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We look forward to hearing from you.

Sincerely,

  
James S. Dilday, Esq.